Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PAIN AND RECOVERY CLINIC

Respondent Name
TRUCK INSURANCE EXCHANGE

MFDR Tracking Number
M4-16-1342-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
JANUARY 20, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that our facility should be paid according to the fee schedule guidelines. We are a CARF accredited facility and should not be subject to the twenty percent fee schedule reduction. I have provided the letter of certification as proof."

Amount in Dispute: $160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2015 June 11, 2015	CPT Code 97545-WH (2 hours) Work Hardening	$25.60 X 2 = $51.20	$160.00
June 8, 2015	CPT Code 97546-WH (4.5 hours) Work Hardening	$57.690	
June 11, 2015	CPT Code 97546-WH (4 hours) Work Hardening	$51.20	
TOTAL		$160.00	$160.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
3. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 1, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service,

personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - NC-Texas non-CARF allowance @80%.
   - W3-Appeal/Reconsideration

Issues

Is the requestor CARF accredited? Is the requestor entitled to additional reimbursement for the work hardening program rendered from June 8, 2015 through June 11, 2015?

Findings

The issue in dispute is whether the work hardening program was paid in accordance with the Division fee guideline.

The respondent reduced reimbursement for the disputed work hardening program based upon reason code “NC-Texas non-CARF allowance @80%.”

The requestor contends that the reduction was inappropriate because Pain and Recovery Clinic is CARF accredited. In support of the position, the requestor submitted a copy of a letter dated June 8, 2015 from CARF International that indicated the accreditation will extend through April 2016; therefore, the respondent’s denial is not supported.

28 Texas Administrative Code §134.204(h)(1)(A) states, “1) Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.”

28 Texas Administrative Code §134.204(h)(3)(A) and (B) states “For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.”

The Division finds that the requestor billed CPT code 97545WH and 97546WH for 12.5 hours. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(A) and (3)(A) and (B), the MAR for a CARF accredited program is $64.00 per hour. $64.00 times the 12.5 hours billed is $800.00. The respondent paid $640.00. The difference between the MAR and amount paid is $160.00. This amount is recommended for additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $160.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $160.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 24, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.